471-000-64 Nebraska Medicaid Billing Instructions for Mental Health and Substance Abuse Services

The instructions in this appendix apply when billing Nebraska Medicaid, also known as the Nebraska Medical Assistance Program (NMAP), for Medicaid-covered services provided to clients who are eligible for fee-for-service Medicaid or enrolled in the Nebraska Medicaid Mental Health/Substance Abuse Managed Care Program. Medicaid regulations for mental health and substance abuse services are covered in 471 NAC 20-000 and 471 NAC 32-000. For a listing of billing instructions for all Medicaid services, see 471-000-49.

Third Party Resources: Claims for services provided to clients with third party resources (e.g., Medicare, private health/casualty insurance) must be billed to the third party payer according to the payer's instructions. After the payment determination by the third party payer is made, the provider may submit the claim to Nebraska Medicaid. A copy of the remittance advice, explanation of benefits, denial, or other documentation from the third party resource must be submitted with the claim.

For instructions on billing Medicare crossover claims, see 471-000-70. For clients who do not have Medicare Part A coverage or who have exhausted Medicare Part A benefits, all Medicare Part B covered services must be submitted to Medicare prior to billing Medicaid for inpatient hospital services.

Verifying Eligibility: Medicaid eligibility, managed care participation, and third party resources may be verified from –

1. The client's monthly Nebraska Medicaid Card or Nebraska Health Connection ID Document. For explanation and examples, see 471-000-123;
2. The Nebraska Medicaid Eligibility System (NMES) voice response system. For instructions, see 471-000-124; or
3. The standard electronic Health Care Eligibility Benefit Inquiry and Response transaction (ASC X12N 270/271). For electronic transaction submission instructions, see 471-000-50.

CLAIM FORMATS

Electronic Claims:

- Community-based (non-hospital) and supervising practitioner mental health and substance abuse services are billed to Nebraska Medicaid using the standard electronic Health Care Claim: Professional transaction (ASC X12N 837). For electronic transaction submission instructions, see 471-000-50.

- Hospital-based mental health and substance abuse services are billed to Nebraska Medicaid using standard electronic Health Care Claim: Institutional transaction (ASC X12N 837). For electronic transaction submission instructions, see 471-000-50.

Paper Claims:

- Community-based (non-hospital) and supervising practitioner mental health and substance abuse services are billed to Nebraska Medicaid on Form CMS-1500, "Health Insurance Claim Form." Instructions for completing Form CMS-1500 are in this appendix.

- Hospital-based mental health and substance abuse services are billed to Nebraska Medicaid on Form CMS-1450, "Health Insurance Claim Form." Instructions for completing Form CMS-1450 are in this appendix.

Share of Cost Claims: Certain Medicaid clients are required to pay or obligate a portion of their medical costs due to excess income. These clients receive Form EA-160, "Record of Health Cost – Share of Cost – Medicaid Program" from the local HHS office to record services paid or obligated to providers. For an example and instructions on completing this form, see 471-000-79.

MEDICAID CLAIM STATUS

The status of Nebraska Medicaid claims can be obtained by using the standard electronic Health Care Claim Status Request and Response transaction (ASC X12N 276/277). For electronic transaction submission instructions, see 471-000-50.

Providers may also contact Medicaid Inquiry at 1-877-255-3092 or 471-9128 (in Lincoln) from 8:00 a.m. to 5:00 p.m. Monday through Friday.

CMS-1500 FORM COMPLETION AND SUBMISSION

Mailing Address: When submitting claims on Form CMS-1500, retain a duplicate copy and mail the ORIGINAL form to –

Medicaid Claims Processing
Health and Human Services Finance and Support
P. O. Box 95026
Lincoln, NE 68509-5026

Claim Adjustments and Refunds: See 471-000-99 for instructions on requesting adjustments and refund procedures for claims previously processed by Nebraska Medicaid.

Claim Example: See 471-000-58 for an example of Form CMS-1500.

Claim Form Completion Instructions: The numbers listed below correspond to the numbers of the fields on the form. Completion of fields identified with an asterisk (*) is mandatory for claim acceptance. Information in fields without an asterisk is required for some aspect of claims processing/resolution. Fields that are not listed are not needed for Nebraska Medicaid claims.

*1a. INSURED'S I.D. NUMBER: Enter the Medicaid client's complete eleven-digit identification number (Example: 123456789 01). When billing for services provided to the ineligible mother of the eligible unborn child, enter the Medicaid number of the unborn child (see 471 NAC 1-002.02K).

*2. PATIENT'S NAME: Enter the full name (last name, first name, middle initial) of the person that received services.

*3. PATIENT'S BIRTHDATE AND SEX: Enter the month, day, and year of birth of the person that received the service. Check the appropriate box (M or F).

4. INSURED'S NAME: Complete only when billing for services provided to the ineligible mother of an eligible unborn child. Enter the Medicaid client's name as it appears on the Nebraska Medicaid Card or Nebraska Health Connection ID Document. This is the name of the person (the unborn child) whose number appears in Field 1a.

9. – 11. Fields 9-11 address third party resources other than Medicaid or Medicare. If there is no known insurance coverage, leave blank. If the client has insurance coverage other than Medicaid or Medicare, complete fields 9-11. A copy of the remittance advice, explanation of benefits, denial, or other documentation is required and must be attached to the claim. Nebraska Medicaid must review all claims for possible third party reimbursement. All third party resources must be exhausted before Medicaid payment may be issued.

*14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY: When billing for residential treatment center, treatment group home, and treatment foster care services, enter the admission date.

*21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY: The services on this claim form must be related to the diagnosis entered in this field. Enter the patient's complete primary diagnosis. If applicable, enter any other psychiatric or medical diagnoses.

The complete International Classification of Disease, 9th Edition, Clinical Modification (ICD-9-CM) diagnosis code must be used. (A complete code may include the third, fourth, and fifth digit, as defined in ICD-9-CM). Up to four diagnoses may be entered. Do not use codes from the Diagnostic and Statistical Manual published by the American Psychiatric Association. ICD-9-CM manuals may be ordered by contacting Med-Index Publications, 5225 Wiley Post Way, Suite 500, Salt Lake City, UT 84116-2889, 1-800-999-4600.

22. MEDICAID RESUBMISSION: Leave blank. For regulations regarding resubmittals or payment adjustment requests, see 471 NAC 3-000 and 471-000-99.

*24. Only six line items can be entered in Field 24. Do not print more than one line of information on each claim line. DO NOT LIST services for which there is no charge.

*24A. DATE(S) OF SERVICE: Enter the 8-digit numeric date of service rendered. Each procedure code/service billed requires a date.

The following services may be billed on a single claim line when the service dates are consecutive and the procedure is the same each day: Inpatient physician services, residential treatment, enhanced treatment group home, treatment group home and treatment foster care. When billing for consecutive dates, enter the begin date (From) and end date (To).

Day treatment and partial hospitalization can not be billed consecutively and must be billed on separate lines. When billing non-consecutive days, only the begin date (From) must be entered and each service must be listed on a separate line.

*24B. PLACE OF SERVICE: Enter the national two-digit place of service code that describes the location the service was rendered. National place of service codes are defined by the Centers for Medicare and Medicaid Services (CMS) and published on the CMS web site at http://www.cms.hhs.gov. The most common national place of service codes are -

03 School
04 Homeless Shelter
05 Indian Health Service Free-standing Facility
06 Indian Health Service Provider-based Facility
07 Tribal 638 Free-standing Facility
08 Tribal 638 Provider-based Facility
11 Office
12 Home
13 Assisted Living Facility
14 Group Home
15 Mobile Unit
20 Urgent Care Facility
21 Inpatient Hospital
22 Outpatient Hospital
23 Emergency Room – Hospital
24 Ambulatory Surgical Center
25 Birthing Center
26 Military Treatment Facility
31 Skilled Nursing Facility
32 Nursing Facility
33 Custodial Care Facility
34 Hospice
41 Ambulance – Land
42 Ambulance – Air or Water
49 Independent Clinic
50 Federally Qualified Health Center

51 Inpatient Psychiatric Facility
52 Psychiatric Facility-Partial Hospitalization
53 Community Mental Health Center
54 Intermediate Care Facility/Mentally Retarded
55 Residential Substance Abuse Treatment Facility
56 Psychiatric Residential Treatment Center
57 Non-residential Substance Abuse Treatment Facility
60 Mass Immunization Clinic
61 Comprehensive Inpatient Rehabilitation Facility
62 Comprehensive Outpatient Rehabilitation Facility
65 End-Stage Renal Disease Treatment Facility
71 Public Health Clinic
72 Rural Health Clinic
81 Independent Laboratory
99 Other Place of Service

*24D. PROCEDURES, SERVICES, OR SUPPLIES: Enter the appropriate national HCPCS procedure code and, if required, procedure code modifier. Up to four modifiers may be entered for each procedure code. See page 13 of this appendix for a partial listing of procedure codes and billing instructions for mental health/substance abuse services. Procedure codes and modifiers used by Nebraska Medicaid are listed in the Nebraska Medicaid Practitioner Fee Schedule (see 471-000-532).

24E. DIAGNOSIS CODE: List the reference number of the primary diagnosis that is being treated as indicated in Field 21. One diagnosis code may be entered per line. Do not enter codes from the DSM-IV.

*24F. $ CHARGES: Enter your customary charge for each procedure code. Do not list one charge for several procedure codes. Payment for services will be made on the basis of the Nebraska Medical Assistance Program's payment methodology.

*24G. DAYS OR UNITS: Enter the number of services being claimed. Some procedure codes are time specific. If the procedure code description includes specific time or quantity increments, each increment should be billed as one unit of service. For example, CPT procedure code 90806 is defined as 45-50 minutes of individual therapy. When billing this service, the correct unit of service is ‘1’.

25. FEDERAL TAX I.D. NUMBER: For outpatient therapy/counseling services, community treatment aides, supervising practitioners, and inpatient physician services, enter the Social Security number of the practitioner providing the service identified on this claim (Service Rendering Provider Number). Only one service rendering provider number may be reported per claim.

26. PATIENT'S ACCOUNT NO.: Optional. Any patient account information (numeric or alpha) may be entered in this field to enhance patient identification. This information will appear on the Medicaid Remittance Advice.

*28. TOTAL CHARGE: Enter the total of all charges in Field 24, Column F. If more than one claim form is used to bill for services provided, EACH claim form must be submitted with the line items totaled. DO NOT carry charge forward to another claim form.

*29. AMOUNT PAID: Enter any payments made, due, or obligated from other sources for services listed on this claim unless the source is from Medicare. Other sources may include health insurance, liability insurance, excess income, etc. A copy of the Medicare or insurance remittance advice, explanation of benefits, denial, or other documentation must be attached to each applicable claim. DO NOT enter previous Medicaid payments or the difference between the provider's billed charge and the Medicaid allowable (provider "write-off" amount) in this field.

*30. BALANCE DUE: Enter the balance due. (This amount is determined by subtracting the amount paid in Field 29 from the total charge in Field 28.)

*31. SIGNATURE OF PHYSICIAN OR SUPPLIER: The provider or authorized representative must SIGN and DATE the claim form. A signature stamp, computer-generated or typewritten signature will be accepted. The signature date must be on or after the dates of service listed on the form.

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED: Enter the name and address of the facility where services were rendered if other than home or office. Example: school, nursing home, group home.

*33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #: Enter the provider's name, address, zip code, and phone number.

PIN NUMBER: Leave blank.

GRP NUMBER: Enter the eleven-digit Nebraska Medicaid provider number as assigned by Nebraska Medicaid (example: 123456789 12). All payments are made to the name and address listed on the Medicaid provider agreement for this provider number.

CMS-1450 FORM COMPLETION AND SUBMISSION

Mailing Address: When submitting claims on Form CMS-1450, retain a duplicate copy and mail the ORIGINAL form to –

Medicaid Claims Processing
Health and Human Services Finance and Support
P. O. Box 95026
Lincoln, NE 68509-5026

Claim Adjustments and Refunds: See 471-000-99 for instructions on requesting adjustments and refund procedures for claims previously processed by Nebraska Medicaid.

Claim Example: See 471-000-51 for an example of Form CMS-1450.

Claim Form Completion Instructions: CMS-1450 (UB-92) completion requirements for Nebraska Medicaid are outlined below. The numbers listed correspond to the CMS-1450 form locators (FL) and are identified as required, situational, recommended or not used. Unlabeled form locators are not included in these instructions. For a summary of form locator requirements for all services, see 471-000-78.

These instructions must be used with the complete CMS-1450 (UB-92) claim form completion instructions outlined in the Nebraska Uniform Billing Data Element Specifications. The Nebraska Uniform Billing Data Element Specifications document is available from the Nebraska Uniform Billing Committee through the Nebraska Hospital Association.

FL	DATA ELEMENT DESCRIPTION	REQUIREMENT
1.	**Provider Name, Address & Telephone Number**	**Required**
3.	**Patient Control Number**	**Required**
	The patient control number will be reported on the Medicaid Remittance Advice.	
4.	**Type of Bill**	**Required**
5.	**Federal Tax Number**	**Recommended**
6.	**Statement Covers Period**	**Required**
7.	**Covered Days**	**Situational**
	Required on all inpatient claims. The admission date may be submitted as a covered day. The discharge date may not be submitted as a covered day, unless the discharge occurs on the same date as admission. If the admission and discharge occurs on the same date, one covered day may be billed. Not used on outpatient claims.	

8. Non-Covered Days **Situational**

Use if applicable.

9. Coinsurance Days **Not Used**

10. Lifetime Reserve Days **Not Used**

12. Patient Name **Required**

The patient is the person that received services. When billing for services provided to the ineligible mother of an unborn child, enter the name of the mother (see 471 NAC 1-002.02K).

13. Patient Address **Recommended**

The patient is the person that received services.

14. Patient Birthdate **Required**

The patient is the person that received services.

15. Patient Sex **Required**

The patient is the person that received services.

16. Patient Marital Status **Not Used**

17. Admission/Start of Care Date **Situational**

Required on all inpatient claims. Required on outpatient claims for emergency rooms, observation rooms, and electroconvulsive therapy.

18. Admission Hour **Situational**

Required on all inpatient claims. Required on outpatient claims for emergency rooms, observation rooms, and electroconvulsive therapy.

19. Type of Admission/Visit **Required**

20. Source of Admission **Required**

21. Discharge Hour **Situational**

Required on all inpatient claims. Required on outpatient claims for emergency rooms, observation rooms, and electroconvulsive therapy.

22. Patient Status **Situational**

Required on all inpatient claims. Required on outpatient claims for emergency rooms, observation rooms, and electroconvulsive therapy.

23. Medical/Health Record Number **Required**

24-30. Condition Codes **Situational**

Use if applicable.

32-35. Occurrence Codes and Dates **Situational**

Required for traumatic diagnoses. Required on outpatient claims for emergency rooms, observation rooms, and electroconvulsive therapy. Use other occurrence codes if applicable.

36. Occurrence Span Code and Dates **Situational**

Use if applicable.

37. Internal Control Number (ICN)/ Document Control Number (DCN) **Situational**

Required on adjustments.

38. Responsible Party Name and Address **Not Used**

39-41. Value Codes and Amounts **Situational**

Use if applicable.

42. Revenue Code **Required**

43. Revenue Description **Not Used**

44. HCPCS/Rates/HIPPS Rate Codes **Situational**

HCPCS procedure codes are required on all mental health/substance abuse claims, except pharmacy and supplies. See page 13 of this appendix for a partial listing of procedure codes and billing instructions for mental health/substance abuse services. Procedure codes and modifiers used by Nebraska Medicaid are listed in the Nebraska Medicaid Practitioner Fee Schedule (see 471-000-532). Up to four procedure code modifiers may be entered for each procedure code.

Rates are required on acute psychiatric inpatient claims for accommodation rooms.

45. Service Date **Situational**

Required on outpatient claims with date spans (FL6) greater than one calendar day, except dialysis, cardiac rehab, and ambulatory room and board services.

46. Units of Service **Required**

Units must be whole numbers. No decimals or fractions are permitted.

47. Total Charges (by Revenue Code Category) **Required**

Total charges must be greater than zero. Do not submit negative amounts.

48. Non-Covered Charges **Situational**

Enter only Nebraska Medicaid non-covered charges. Do not submit negative amounts.

50. Payer Identification **Not Used**

51. Provider Number **Required**

Enter the eleven-digit Nebraska Medicaid provider number as assigned by Nebraska Medicaid (example: 123456789-12). All payments are made to the name and address listed on the Medicaid provider agreement for this provider number.

52. Release of Information Certification Indicator **Not Used**

53. Assignment of Benefits Certification Indicator **Not Used**

54. Prior Payments - Payers and Patient **Situational**

Enter any payments made, due, or obligated from other sources for services listed on this claim unless the source is from Medicare. Other sources may include health insurance, liability insurance, excess income, etc. A copy of the explanation of Medicare or insurance remittance advice, explanation of benefits, denial, or other documentation must be attached to each claim when submitting multiple claim forms.

DO NOT enter previous Medicaid payments, Medicaid copayment amounts, Medicare payments, or the difference between the provider's billed charge and the Medicaid allowable (provider "write-off" amount).

55. Estimated Amount Due **Not Used**

58. Insured's Name **Required**

When billing for services provided to the ineligible mother of an eligible unborn child, enter the name of the unborn child as it appears on the Nebraska Medicaid Card or Nebraska Health Connection ID Document.

59. Patient's Relationship to Insured **Required**

Use patient relationship code 18 for all claims.

60. Certificate/Social Security Number/Health Insurance Claim/Identification Number **Required**

Enter the Medicaid client's complete eleven-digit identification number (example: 123456789-01). When billing for services provided to the ineligible mother of an eligible unborn child, enter the Medicaid number of the unborn child.

61. Insured Group Name **Situational**

Recommended when Nebraska Medicaid is the secondary payer.

62. Insurance Group Number **Situational**

Recommended when Nebraska Medicaid is the secondary payer.

63. Treatment Authorization Code **Situational**

Required on all inpatient claims. Required on outpatient claims for partial hospitalization. Required for outpatient therapy services for clients participating in the Nebraska Medicaid mental health/substance abuse managed care plan.

64. Employment Status Code of the Insured **Not Used**

65. Employer Name of the Insured **Not Used**

66. Employer Location of the Insured **Not Used**

67. Principal Diagnosis Code **Required**

The COMPLETE ICD-9-CM diagnosis code is required. A complete code may include the third, fourth, and fifth digits, as defined in ICD-9-CM. Do not use DSM-IV codes.

68-75. Other Diagnosis Codes--ICD-9-CM **Situational**

Required if more than one diagnosis applies to the services on this claim.

76. Admitting Diagnosis/Patient's Reason for Visit **Situational**

Required on all inpatient claims. Required on outpatient claims for emergency room services.

77. External Cause of Injury Code (E-Code) **Situational**

Required if the principal diagnosis is trauma.

79. Procedure Coding Method Used **Not Used**

80. Principal Procedure Code and Date **Not Used**

81. Other Procedure Codes and Dates **Not Used**

82. Attending Physician ID **Required**

The practitioner license number must begin with the two-digit state abbreviation followed by the state license number (example: NE123456).

Enter the attending practitioner's last and first name.

83. Other Physician ID **Not Used**

84. Remarks **Situational**

Use to explain unusual services and to document medical necessity, for example, when unit limitations are exceeded. Required for outpatient stays greater than 24 hours.

85. Provider Representative Signature **Required**

The provider or authorized representative must sign the claim form. A signature stamp, computer-generated, or typewritten signature will be accepted.

86. Date Bill Submitted **Required**

The signature date must be on or after the last date of service listed on the claim.

Procedure Codes and Billing Instructions for Mental Health/Substance Abuse Services:

Community Treatment Aide I: Use procedure code G0177 and modifier HN (Training and educational services related to the care and treatment of patient's disabling mental health problems, per session 45 minutes or more). One unit is 60 minutes. Report the number of units per visit. Bill on Form CMS-1500.

Community Treatment Aide II: Use procedure code G0177 and modifier HM (Training and educational services related to the care and treatment of patient's disabling mental health problems, per session 45 minutes or more). One unit is 60 minutes. Report the number of units per visit. Bill on Form CMS-1500.

Day Treatment and Partial Hospitalization, Full Day: Use procedure code H2012 (Behavioral health day treatment, per hour). Each full day service must be billed on a separate claim line. The unit of service for each line must be reported as 6. Bill day treatment on Form CMS-1500 and partial hospitalization on Form CMS-1450.

Day Treatment and Partial Hospitalization, Half-Day: Use procedure code H2012 and modifier 52 (Behavioral health day treatment, per hour). Each half-day service must be billed on a separate claim line. The unit of service for each line must be reported as 3. Bill day treatment on Form CMS-1500 and partial hospitalization on Form CMS-1450.

Day Treatment, Extended Day: Use procedure code H2012 and modifier TU (Behavioral health day treatment, per hour). Report the number of hours provided. Bill on Form CMS-1500.

Family Assessment: Use procedure code H1011 (Family assessment by licensed behavioral health professional for state defined purposes). Report one unit per assessment. Bill community-based (non-hospital) services on Form CMS-1500 and hospital-based services on Form CMS-1450.

Intensive Outpatient Service (Bundled): Use procedure code S9480 (Intensive outpatient psychiatric services, per diem). This service is bundled for managed care clients only. For fee-for-service clients, bill each service separately. Bill community-based (non-hospital) services on Form CMS-1500 and hospital-based services on Form CMS-1450.

Mileage: Use procedure code 99082. The unit of service must be billed as the total number of miles traveled. Bill on Form CMS-1500.

Pre-Treatment Assessment: Use procedure code H0002 (Behavioral health screening to determine eligibility for admission to treatment program). Bill community-based (non-hospital) services on Form CMS-1500 and hospital-based services on Form CMS-1450

Addendum to the Pre-Treatment Assessment: Use procedure code H0002 and modifier 52 (Behavioral health screening to determine eligibility for admission to treatment program). Bill community-based (non-hospital) services on Form CMS-1500 and hospital-based services on Form CMS-1450.

Psychological Testing: Use procedure code 96100 for each hour of testing. Use procedure code 96100 and modifier 52 for ½ hour of testing. Bill community-based (non-hospital) services on Form CMS-1500 and hospital-based services on Form CMS-1450.

Supervising Practitioner (M.D. or Ph.D.) Services: Use the appropriate procedure code for the service. Bill on Form CMS-1500.

Day Residential Crisis Intervention (up to 23 hours and 59 minutes): Use procedure code S9484 (Crisis intervention mental health services, per hour). Report the number of hours as the units of service. Bill on Form CMS-1450.

Residential Acute Crisis Intervention: Use procedure code S9485 (Crisis intervention mental health services, per diem). Bill community-based (non-hospital) services on Form CMS-1500 and hospital-based services on Form CMS-1450.

Residential Treatment Center:

- For hospital-based services, use procedure code H0017 and modifier TG (Behavioral health; residential (hospital residential treatment program), without room and board, per diem). When the service includes room and board, use modifier U1 (Service includes room and board) as the second modifier. For newly enrolled facilities that are not nationally accredited, modifier U1 should not be used since the Medicaid payment rate does not include room and board. Bill on Form CMS-1450.

- For community-based (non-hospital) services, use procedure code H0018 and modifier TG (Behavioral health; short-term residential (non-hospital residential treatment program), without room and board, per diem). When the service includes room and board, use modifier U1 (Service includes room and board) as the second modifier. For newly enrolled facilities that are not nationally accredited, modifier U1 should not be used since the Medicaid payment rate does not include room and board. Bill on Form CMS-1500.

Therapeutic Leave Days: When billing therapeutic leave days on Form CMS-1500, report the procedure code for the service the client is receiving and place of service code 12. When billing therapeutic leave days on Form CMS-1450, report the procedure code for the service the client is receiving and revenue code 183.

Treatment Foster Care: Use procedure code S5145 (Foster care, therapeutic, child; per diem). Bill on Form CMS-1500.

Treatment Group Home:

- For hospital-based services, use procedure code H0017 (Behavioral health; residential (hospital residential treatment program), without room and board, per diem). When the service includes room and board, use modifier U1 (Service includes room and board) as the second modifier. For newly enrolled facilities that are not nationally accredited, modifier U1 should not be used since the Medicaid payment rate does not include room and board. Bill on Form CMS-1450.

- For community-based (non-hospital) services, use procedure code H0018 (Behavioral health; short-term residential (non-hospital residential treatment program), without room and board, per diem). When the service includes room and board, use modifier U1 (Service includes room and board) as the second modifier. For newly enrolled facilities that are not nationally accredited, modifier U1 should not be used since the Medicaid payment rate does not include room and board. Bill on Form CMS-1500.

Enhanced Treatment Group Home:

- For hospital-based services, use procedure code H0017 and modifier TF (Behavioral health; residential (hospital residential treatment program), without room and board, per diem). When the service includes room and board, use modifier U1 (Service includes room and board) as the second modifier. For newly enrolled facilities that are not nationally accredited, modifier U1 should not be used since the Medicaid payment rate does not include room and board. Bill on Form CMS-1450.

- For community-based (non-hospital) services, use procedure code H0018 and modifier TF (Behavioral health; short-term residential (non-hospital residential treatment program), without room and board, per diem). When the service includes room and board, use modifier U1 (Service includes room and board) as the second modifier. For newly enrolled facilities that are not nationally accredited, modifier U1 should not be used since the Medicaid payment rate does not include room and board. Bill on Form CMS-1500.

Telehealth Services: Medicaid policy regarding telehealth services is covered in 471 NAC 1-006. To bill for a telehealth service, use the standard CPT/HCPCS procedure code for the service (e.g., office visit, consultation) with procedure code modifier GT. To bill for telehealth transmission costs, use procedure code T1014 and enter the number of minutes of transmission as the units of service. When billing for outpatient services or for supervising practitioner services at the higher levels of care, each day the service is provided via telehealth must be listed on a separate line. For these days, there should also be a separate line billed for the telehealth transmission cost. There is no additional reimbursement for the telehealth transmission charges for these levels of care, but Nebraska Medicaid must track and analyze the use of telehealth services. Bill community-based (non-hospital) services on Form CMS-1500 and hospital-based services on Form CMS-1450.